

# Sick Leave Bank

## Authorization for Sick Leave Participation

Name:

Department:

### VOLUNTARY ENROLLMENT

I wish to enroll in the Madison County Sick Leave Bank and I hereby authorize Madison County to transfer 8 hours of my accrued Sick Leave to the Sick Leave Bank. I understand that the 8 hours is not revocable, but will remain in the Bank for use by eligible recipients. Membership in the Sick Leave Bank affords me the opportunity to request leave time should I be faced with a catastrophic medical emergency. Membership also enables me to donate leave to the Bank and/or to a designated qualified recipient. I understand that I may withdraw my membership at any time. Should I withdraw my membership, I understand that I will not be able to renew my membership until the designated enrollment period.

Employee Signature

Date

### I DECLINE

I **do not** wish to enroll in the Sick Leave Bank at this time. I understand that I will not be eligible for the benefits of the Bank. I further understand that **I will only be able to enroll after completing my 6 month probationary period (you have 30 days) or during open enrollment.**

Employee's Signature

Date